REVIEW OF STANDARD SERVICE ORGANIZATION DETERMINATIONS (excludes expedited organization determinations) WS-AP3

ID/Member Name/Type	Date Service Request Received	Date Notice Mailed	Processed Within 14 Days?* (Standard) If extension granted, enrollee notified in writing?	Denial Proper?	Correct Appeal Language Provided?	POS?	Comments

Standard: 95 percent correct.

Determination: Transfer results of this sample to the appropriate requirements of the Appeals Section of the *Review Guide*. See Column Explanations for coded requirements related to specific columns. *See next page.

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Requirement:

*ALL STANDARD SERVICE RELATED DECISIONS MUST BE MADE AS EXPEDITIOUSLY AS THE ENROLLEE'S HEALTH CONDITION REQUIRES BUT NO LATER THAN 14 CALENDAR DAYS AFTER THE DATE THE M+CO RECEIVES THE REQUEST. THE M+CO MAY EXTEND THE TIMEFRAME BY UP TO 14 CALENDAR DAYS IF THE ENROLLEE REQUESTS THE EXTENSION OR IF THE M+CO JUSTIFIES A NEED FOR ADDITIONAL INFORMATION AND HOW THE DELAY IS IN THE INTEREST OF THE ENROLLEE.

The M+CO must make an organization determination (the M+CO's decision to provide, to authorize or to deny a service) within: 1) 14-calendar days of the enrollee's request for the service, 2) or expiration of the extension ~~(which may be up to 14 calendar days, if the enrollee requests it or if an extension is in the interest of the enrollee)~~. Failure to provide a notice constitutes an adverse organization determination which the member may appeal. The M+CO must notify the member if it has failed to make a timely decision. Failure to make a timely decision constitutes an adverse determination, and the M+CO must include Appeal Rights.

Purpose: To determine whether the M+CO complies with regulatory requirements of identifying organization determinations involving a request for a service, in a timely manner. To determine whether the M+CO inappropriately denied services; e.g., Medicare-covered services, emergency, urgently needed, and post stabilization care, as well as temporarily out of area renal dialysis services, services rendered pursuant to a POS benefit, and supplemental (mandatory and optional) benefits covered in the M+CO's subscriber agreement.

Sample: In the notification of a site visit letter, a reviewer will request the M+CO to provide a list of all approved and denied preauthorization/authorization cases. (Note: If the M+CO delegates this function to medical groups or IPAs, ask for lists from the groups) in the 6-month period ending with the month prior to the scheduled visit (the specific months should be specified in the letter). If the M+CO offers a POS benefit, be sure to include any POS cases that require preauthorization/authorization from the M+CO (or delegated entities). Depending upon the number of enrollees in the POS product, the reviewer may, at his or her discretion, request a separate universe of POS-only preauthorizations/authorizations for review.

Upon receipt of the list, approximately two weeks prior to the site visit, the reviewer will select 30 cases of plan preauthorizations/authorizations (if the plan contracts with multiple groups, select a sample that includes preauthorizations/authorizations from at least three groups) in accordance with the random selection methods discussed in the *Review Guide*, Instructions under Sampling Methodology. ***(Note: During focused reviews, HCFA staff may elect to increase sample sizes to 100 cases or more, as deemed appropriate by the Agency.)*** Five (5) to seven (7) days before the site visit, the reviewer will notify the M+CO of the specific units of analysis. The M+CO will have all necessary documentation for the units of analysis available upon the reviewer's arrival onsite.

Column Explanations:

❑ **ID/Member Name/Type:** Self-explanatory. Number optional.
❑ **Date Service Request Received:** Self-explanatory.
❑ **Date Denial Notice Mailed:** Self-explanatory. [42 CFR 422.568~~(c)~~ (d) requires a written notice if an M+CO decides to deny service, in whole or in part.]
❑ **Processed within 14-Calendar Days:** Did the M+CO render a decision and notify the enrollee within 14 calendar days of the request? [A 14 calendar day extension is permissible, if the extension is requested by the enrollee or if the extension is in the enrollee's interest] If an extension was granted, did the M+CO notify the enrollee in writing? Transfer results to AP01, AP03.
❑ **Denial Proper:** Was a written denial notice issued and does the notice clearly explain the reason for the denial in language that the enrollee can understand? "Not a covered benefit" or "Medical Necessity not Met" does not give sufficient information to explain the denial. Transfer results to ~~AP03~~, AP04, AP05.
❑ **Correct Appeal Language Provided:** Were full written appeal rights given? Does the notice include the correct address for filing the appeal? Transfer results to ~~AP01, AP04~~, AP05.
❑ **POS?: Was this a POS benefit?**
❑ **Comments:** Self-explanatory. You may want to include comments here (e.g., reason for denial) that would help you focus on trends.

NOTE TO REVIEWER: If the M+CO is unable to provide a universe (or if a delegated entity cannot provide a universe), have the M+CO (or delegated entity) provide a list of members who have recently changed PCPs. Have the M+CO (delegated entity) provide the reason codes for the PCP changes. Review the list. If the M+CO (delegated entity) does not capture the reason for

PCP change, call ten (or more) members from the list at random. If it appears that members have changed PCPs because they were not receiving referrals or services they felt they needed, but they were not receiving appeal rights when referrals/services were denied, consider requiring the M+CO (delegated entity) to post signs in offices where health care is delivered related to the Medicare appeal process, including an M+CO telephone number to call for questions.